CONSENT FOR COVID-19 VACCINE DOSE 2

SECTION 1: INFORMATION ABOUT PATIENT TO RECEIVE VACCINE (PLEASE PRINT)

PATIENT'S NAME (Last)	(First), (M.I.)	PATIENT'S DATE OF BIRTH:	PT'S AGE:

PARENT/LEGAL GUARDIAN'S NAME (Last): IF PT IS MINOR	(First), (M.I.)	PATIENT'S GENDER: M / F

ADDRESS	City/State/Zip

FOR VACCINE RECIPIENTS:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today?	**YES**	**NO**	**DON'T KNOW**
2. Are there any changes in health history since Dose 1?	**YES**	**NO**	**DON'T KNOW**
3. Any severe reaction to Dose 1?	**YES**	**NO**	**DON'T KNOW**

(This would be a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)

SECTION 4: CONSENT I have reviewed the information on risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine and COMIRNATY (COVID-19 VACCINE, mRNA) and understand the risks and benefits. In providing my consent below,

I agree that:

• I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine, available at https://www.fda.gov/media/144414/download. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination.

• I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

I GIVE CONSENT to Clinical Pediatric Associates of North Texas to vaccinate the patient named at the top of this form with the applicable Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY (COVID-19 VACCINE, mRNA) and have reviewed and agree to the information included in Section 4 of this form.

_____ _____

Signature of the Patient if 18 years old & over — Date signed

_____ _____

Signature of the Parent/Legal Guardian named above — Date signed